STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATION

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE: BLUE CROSS & BLUE SHIELD :
OF RHODE ISLAND CLASS DIR :
DATED NOVEMBER 20, 2006 :

PRE-FILED DIRECT TESTIMONY OF
JOHN LYNCH

I. INTRODUCTION

Q. Please state your name and professional qualifications.

A. My name is John Lynch. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Q. By whom are you employed?

A. I am employed by Blue Cross & Blue Shield of Rhode Island (Blue Cross).

Q. What is your title and area of specialization as an employee of Blue Cross?

A. My title is Chief Actuary and I oversee Blue Cross' Actuarial department. The key responsibility of this area is developing and maintaining premium rate structures that are actuarially sound, competitive in the marketplace and meet the company's financial and operational goals. My duties also include setting claim reserve levels and overseeing all other actuarial functions.

Q. How long have you been employed by Blue Cross in that capacity?

BLUE CROSS EXHIBIT 1

A. I have been employed in that capacity for the last 15 months. I was hired into this position on July 27, 2005.

Q. Please describe your actuarial responsibilities and your experience with respect to actuarial matters prior to joining Blue Cross.

A. For the ten year period prior to joining Blue Cross (i.e. from 1995 until 2005) I was the Chief Actuary of Horizon BCBSNJ, the Blue Cross plan of New Jersey. I was responsible for making rate filings, setting reserve levels and overseeing all other actuarial functions. For the period 1970 until 1995 I was employed by MetLife. I was hired into their actuarial student program and during my time there I held various positions of increasing responsibility primarily in their Group Life and Health operations. At the time I left Met I was a VP & Actuary and managed staff responsible for all contract and rate filings associated with their large group operations as well as the associated financial analyses for such business.

Q. Have you previously qualified and been accepted as an expert on actuarial matters in proceedings before the Office of Health Insurance Commissioner (OHIC)?

A. In connection with our filing of the 2005 Annual Statement I signed the required Statement of Actuarial Opinion and such statement was accepted by the OHIC. The required Statement of Actuarial Certification attesting to Blue Cross' compliance with the Small Employer Health Insurance Availability Act was signed by me and accepted by the OHIC. Additionally numerous rate filings have been submitted to the OHIC over my signature during the last 15 months.

[Offer as an expert witness on actuarial rate matters.]

II. DESCRIPTIONS AND BACKGROUND INFORMATION.

Q. I am showing you a document marked as Blue Cross Exhibit 2 for identification purposes. Would you please explain what this is?

A. Yes. This is a letter, dated November 20, 2006, that I wrote to the Health Insurance Commissioner notifying him of the filing of new subscription rates by Blue Cross for Class DIR and summarizing the content and purpose of the filing, which accompanied that letter.

Q. Is Blue Cross Exhibit 2 for identification an accurate summary of Blue Cross' filing for new Direct Pay subscription rates?

A. Yes.

Q. Would you please briefly describe the Class DIR classification?

A. Yes. Class DIR is the rating classification for enrolled subscribers who are neither eligible for employer based coverage (other than as a self employed individual) nor State or Federal programs at the time of enrollment and who have enrolled in one of the individual products. Enrollment is either through direct application or through conversion from prior group coverage.

Two rating pools are employed: (a) Basic rates (Pool I), utilizing specific community rates for all subscribers under age 65 and for subscribers ages 65 and older; and (b) Preferred rates (Pool II), with rates determined on the basis of the age and gender of the subscriber. An annual open enrollment period is conducted for the Basic (Pool I) plan, while enrollment under the Preferred (Pool II) plan is available continuously throughout the year for applicants passing a health screening.

Products currently available under Basic (Pool I) and Preferred (Pool II) include HealthMate Direct 400, HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000. A general description of these products is included in Mr. Boyd's policy testimony.

Q. When was the last rate increase implemented for the Direct Pay Class?

A. The last rate increase was effective April 1, 2006. This was the result of a filing for Class DIR that was submitted to the OHIC on October 28, 2005. On February 20, 2006 the rate filing was approved with some modifications.

Q. As a result of the February 20, 2006 decision by the OHIC, can you quantify what the modifications were that were made?

A. Yes. 2% was deducted from the rates along with some stipulations on some policy actions.

Q. Was there disagreement with the actuarial development or assumptions identified in the decision?

A. No. There was not any disagreement with the actuarial development or assumptions.

Q. I am showing you a document marked as Blue Cross Exhibit 3 for identification. Would you please identify it?

A. These are actuarial schedules that were enclosed with Exhibit 2 and submitted as support of the calculation of the required rates for both Basic (Pool I) and Preferred (Pool II). They apply to Class DIR for the rate year commencing April 1, 2007. Blue Cross Exhibit 3 consists of Schedules 1 through 65.

Q. Are the required rates the same for comparable products between Basic (Pool I) and Preferred (Pool II)?

A. No. As I indicated previously, Basic (Pool I) utilizes community rates, while Preferred (Pool II) rates vary by the underwritten subscriber's age and gender. Furthermore, the development of their respective required rates in this filing reflects some of the difference in claims expense levels experienced between Basic (Pool I) and Preferred (Pool II).

Q. How does this difference in claims expense levels experienced by Blue Cross between Basic (Pool I) vs. Preferred (Pool II) affect the respective required rates?

A. It causes the underlying level of the Preferred (Pool II) rates to be relatively lower, and correspondingly the level of the Basic (Pool I) rates to be relatively higher.

Q. Does this reflection of a portion of the difference in experience between pools affect the overall aggregate amount of premium revenue required by Blue Cross for Class DIR in total?

A. No. The aggregate premium revenue required is unchanged.

Q. Does the fact that only a portion of the experience difference is utilized to separate the rates for the two pools imply that one pool has some subsidization effect on the other pool?

A. That is correct. The Basic rates (Pool I) are subsidized to some degree by the Preferred (Pool II) rates.

Q. How did Blue Cross determine the amount of subsidy that the Preferred rates (Pool II) should provide to the Basic rates (Pool I)?

A. As discussed in the Health Insurance Commissioner's Decision of February 20, 2006, establishing the appropriate level of cross subsidy between the two pools involves trade-offs and there is no public policy consensus as to how to strike a correct balance between the desire to subsidize the rates for high cost risks with the need to offer low cost risks

rates attractive enough to get them to participate in sufficient numbers to keep the overall program sound. We believe that in order to have a vibrant Direct Pay market we have to maintain and if possible grow participation rates for the best risks. Failing to attract large numbers of low cost risks ultimately leads to cost increases for high cost risks and results in our covering fewer of them than we might if we didn't work at maintaining/increasing Pool II enrollment. It is also worth noting that uninsurance levels in RI are highest among young adults who could in large numbers qualify for Pool II rates. Age tends to correlate with both income and with the perceived and actual value of health insurance. Accordingly we felt that reducing the Pool II subsidy of Pool I rates would tend to increase aggregate Direct Pay enrollment beyond what it would otherwise be.

In setting the relationships for this rating period we reviewed the experience of the pools separately. The Basic pool (Pool I) experience on its own indicated that a 14.4% increase was necessary. The Preferred pool (Pool II) experience indicated that a 6.9% decrease was possible. In order to keep the magnitude of the Basic pool's (Pool I) increase in a reasonable level and maintaining its "affordability" aspect, we decided that we would limit the Basic pool (Pool I) to an 8.9% increase. In order to meet the overall premium requirements of the Direct Pay Market, this meant that the Preferred pool (Pool II) would need a 5.4% increase. We believe the existence of the Premium Assistance Program, especially with its proposed expansion reduces the need for a Pool I and Pool II cross subsidy.

Q. Did you prepare or cause to be prepared Blue Cross Exhibit 2 for identification and the actuarial schedules attached thereto, marked as Blue Cross Exhibit 3?

A. Yes. These rate calculations and the actuarial assumptions and methodology underlying the required rates were developed under my direction by the actuarial staff at Blue Cross.

Q. Are you of the opinion that these rate calculations and the actuarial assumptions and methodology underlying these required rates are actuarially sound?

A. Yes.

Q. Would you please describe in general terms the purpose of this filing?

A. The purpose of the filing is to seek approval of new subscription rates to be effective for the April 1, 2007 billing cycle. The filing schedules are intended to provide actuarial justification for the required rates needed by Blue Cross in order for the products to be financially self-supporting, both in the interest of its subscribers and its mission to provide quality health insurance programs.

The required subscription rates must provide for the expected costs of the products and contribute to the financial needs of Blue Cross. Such required rates are intended to provide sufficient income during the new rate period to cover the costs of subscribers' incurred claims for this period and to administer the programs. In addition, the required rate levels must include a reserve component that will contribute Class DIR's fair share toward maintaining corporate reserves at an adequate level. The required rates also provide subscribers an investment income credit.

Q. Would you please describe, in general terms, any product changes being proposed in connection with the subscription rates developed in this filing?

A. Yes. Since there was considerable modification to the product portfolio for Class DIR in the last filing, we are trying to limit the amount of changes to the products this

year. However, there are a couple areas where changes make sense and also help to address the affordability issue. Specifically, on our two HealthMate Direct plans, introducing managed care programs for prescription drug coverage and radiology services are two claims-saving changes that we propose to implement for Class DIR. The Managed Pharmacy Program will save approximately 3.9% on prescription drug claims, or roughly 1% to the bottom-line rates for HealthMate Direct 400 and HealthMate Direct 2000. The Radiology Management Program (recommended preauthorization on radiology services and medical necessity review of services which have not been submitted for preauthorization) will be effective January 2008 and will save roughly .1% on bottom-line rates for this rating period and we expect will help dampen cost trends for imaging services going forward. More details on these programs are provided in the testimony of Mr. Boyd.

Q. Does Blue Cross propose any rate structure changes with either the Basic (Pool I) or the Preferred (Pool II) subscription rates that have been developed in this filing?

A. No. Some changes were made to the rate structure for the Preferred (Pool II) subscription rates in the previous filing but no rate structure changes have been proposed for this filing.

Q. Would you please describe the enrollment changes in Class DIR over the past few years?

A. Yes. As of December 2004 there were approximately 14,200 members enrolled in Class DIR. Preferred (Pool II) represented about 42% of the total enrollment at that time. On a monthly basis from December 2004 to December 2005 there have been about 450 to 650 disenrollments and roughly 500 to 700 new member enrollments. As of December 2005 there were approximately 15,600 members enrolled in Class DIR. As of March 2006 there were

approximately 15,800 members. Since then, the enrollment has declined. As of August 2006, there were approximately 14,300 members enrolled in Class DIR and Preferred (Pool II) represented about 45% of the Class DIR enrollment.

Q. What is the significance of the Preferred (Pool II) percentage?

A. As mentioned previously in my testimony, assuring that Preferred (Pool II) is attractive in the market is critical to sustaining the Direct Pay market. The financial stability of the entire Class DIR is dependent to a significant degree on the continuing ability of Blue Cross to attract subscribers into Preferred (Pool II) since they help to subsidize Basic (Pool I). As a consequence, it is important that Preferred (Pool II) rates bear a reasonable relationship to the pool's own underlying experience level and not be higher than necessary, in order to balance attractiveness in the market with some continuing subsidy of Basic (Pool I). The entire Class DIR pool would be on a financially sounder basis if the Pool I subsidy could be generated from a smaller Pool II surcharge collected from a larger Pool II enrollment.

Q. Let us turn now to Blue Cross Exhibit 3, namely the actuarial schedules enclosed with the filing letter marked as Exhibit 2. Please describe for us of what Schedules 1 through 4 consist.

A. Schedules 1 through 4 constitute the table of contents for the actuarial Schedules in Exhibit 3 that display and support the calculations of the required subscription rates for the April 1, 2007 billing cycle for Class DIR. The actuarial Schedules are grouped into sections, labeled as Section I through Section X.

Q. Please describe briefly what is contained in each of these ten sections.

A. Section I consists of Schedules 5 through 10, which summarize the calculations of the Basic (Pool I) monthly subscription rates for the April 2007 billing cycle.

The monthly subscription rates for each of the Class DIR products for Basic (Pool I) subscribers are displayed separately for those under age 65 vs. ages 65 and over, and by Individual vs. Family contract type.

Section II consists of Schedules 11 through 16, which summarize the calculations of the Preferred (Pool II) required monthly subscription rates for the April 2007 billing cycle. These schedules display the monthly subscription rates for each of the Class DIR products for Preferred (Pool II) subscribers by age, gender, and Individual vs. Family contract type.

Section III consists of Schedules 17 through 22, which summarize the calculation of the Basic (Pool I) and Preferred (Pool II) monthly base rates for each of the products. This includes the development of the required rates for the two pools within Class DIR overall, so that they can be experience-adjusted.

Section IV consists of Schedules 23 through 31, which summarize the claims impacts from state mandated benefits, new technology, and state assessments. Schedule 24 shows a summary of the overall impacts of each mandate or assessment, while the subsequent schedules show the detail behind each one.

Section V consists of Schedules 32 through 36, which calculate the rate period projected incurred claims expense for Basic (Pool I) subscribers. Schedules 34 through 36 calculate the projected allowed claims PCPM for Basic (Pool I) for former products Direct Blue Standard, Direct Blue Economy, and HealthMate Direct 2000, respectively, all adjusted to the Direct Blue Standard former product level. Schedule 33 calculates projected incurred claims expense PCPM for the current products that were effective April 2006, based on projected Standard basis allowed claims for the prior products under Basic (Pool I), coupled with

subscriber migration data for the current products and corresponding benefit adjustment factors for each of them.

Section VI consists of Schedules 37 through 41, which calculate the rate period incurred claims expense for Preferred (Pool II) subscribers. These five schedules for Preferred (Pool II) correspond to Schedules 32 through 36 for Basic (Pool I).

Section VII consists of Schedules 42 through 52, which summarize the calculations of the benefit adjustments, claims-saving adjustments, and contractual adjustment factors for the prior Classic Direct products and each of the four current products. Schedules 43 through 45 calculate the claims savings adjustment factors. Schedule 46 summarizes the calculation of the benefit adjustment factors for each product, reflecting projected claims expense as a percent of projected allowed claims. Schedules 47 through 50 calculate the medical (non-drug) net-to-allowed factors for the HealthMate Direct 400 and HealthMate Direct 2000 products and the composite net-to-allowed factors for the HealthMate for HSA 3000 and HealthMate for HSA 5000 plans. Schedule 51 calculates the net-to-allowed factors for the free-standing prescription drug benefit, and Schedule 52 calculates the contractual adjustment factor to reflect differences in provider contract payment levels between HealthMate and Classic provider agreements.

Section VIII consists of Schedules 53 through 55, providing the administrative expense estimates and calculations.

Section IX consists of Schedules 56 through 58, and calculates the required monthly subscription rates for Organ Transplant coverage.

Section X consists of Schedules 59 through 65, and contains trends and projection factors. As part of this, under separate cover, Schedule 60 is being submitted on a confidential

basis. This schedule displays trend "Projection Factors" for incurred allowed claims projections for the various lines of business.

III. RATING METHODOLOGY USED IN FILING

Q. Can you please provide an overview of the approach used by Blue Cross to calculate the required rates for Class DIR?

A. Yes. The actuarial development of required rates for this filing closely parallels the methodology used last year. The basic approach was to begin with base period incurred allowed claims, separately for Basic (Pool I) and Preferred (Pool II). To avoid seasonality concerns we choose a twelve month base period which is our usual practice. To avoid the complexity of having to combine both new and old portfolio experience we choose a base period that consists of allowed claims incurred over the 4/1/2005 to 3/31/2006 time frame. These allowed claims, expressed on a per contract per month (PCPM) basis, were then adjusted to a consistent product basis. For this purpose, the Direct Blue Standard product was used because it had the largest enrollment over the experience period. The resulting allowed claims PCPM for the base period, adjusted to the Direct Blue Standard level, were then projected to the rate period using projection factors which reflect anticipated trends in allowed claims levels. This process produced projected allowed claims PCPM, adjusted to Direct Blue Standard, for each of the products within Basic (Pool I) and Preferred (Pool II).

The next step was to develop projected incurred claims expense amounts PCPM for each of the current products offered effective April 1, 2006 within Basic (Pool I) and Preferred (Pool II). This step entailed the application of subscriber migration data to map subscribers and their respective projected allowed claims from each of the three prior products into the four current product options. The migration percentages used were the actual results of subscriber enrollment at March 2006 compared to June 2006. Then, benefit adjustment factors

reflecting benefit costs or claims expense under each of the current products relative to Direct Blue Standard allowed claims were applied to the projected allowed claims to produce projected incurred claims expense PCPM amounts for each current product in the two respective pools. From these amounts, a composite projected incurred claims expense PCPM was calculated for each pool. These calculations and results are presented in the schedules contained in Sections V and VI for Basic (Pool I) and Preferred (Pool II), respectively.

The next major stage in the rate development was to determine the required monthly base rates for each of the four products within Basic (Pool I) and Preferred (Pool II). This stage begins with the composite projected incurred claims expense PCPM for each pool, which I have just described. The impact of benefit mandates, new technology, and state assessments was then applied to the projected incurred claims cost. The detail behind the benefit mandates, new technology, and state assessments is in Section IV. To this expense was added retention (administrative expense, investment income credit, reserve contributions, and tax) to calculate required income PCPM by pool and then overall for Class DIR. Consistent with these PCPM values are calculated required loss ratios for each pool and overall for Class DIR.

The overall required income PCPM for Class DIR is the amount that must be produced by the base rates for Class DIR as a whole. The separate amounts PCPM for Basic (Pool I) and Preferred (Pool II) would be the amounts used in developing the base rates for each of the pools, respectively, if the separate experience of the two pools were to form the sole basis for rates. This experience has not been the basis used in the past, and we chose not to use it as the sole basis in this filing. Instead, we elected to partially reflect the separate experience of the two pools.

In order to achieve this result, projected loss ratios were calculated, by pool, on two alternative bases. The first basis was the calculated required loss ratio by pool, which I have just described. The second basis was projected loss ratios calculated from the current alignment of rates between Basic (Pool I) and Preferred (Pool II). The second set of loss ratios – the current pool rate alignment loss ratios – were calculated using the same projected incurred claims expense PCPM amounts by pool as for the first set of loss ratios, divided by the current product present rate income PCPM amounts by pool, adjusted to the required level for Class DIR as a whole.

The experience-adjusted projected loss ratio for Basic (Pool I) was set by deciding to increase Basic (Pool I) rates by a uniform 9% prior to the application of Organ Transplant reinsurance. As discussed earlier in my testimony the 9% rate increase (which equates to 8.9% after factoring Organ Transplant reinsurance) was chosen as a reasonable compromise between our desire to keep Pool I rates affordable and our desire to reduce the Pool II subsidy of Pool I rates. Since the overall projected loss ratio for Class DIR should not change as a result of this alignment of rates between pools, the corresponding experience-adjusted projected loss ratio and experience-adjusted required income PCPM for Preferred (Pool II) were then calculated directly.

The last step in calculating base rates was to apply rate relativity factors, by product, to the pool experience-adjusted composite required base rate amounts PCPM. These calculations and results are presented in the schedules contained in Section III. The "Rate Relativity Factors" are the same as those used in last year's filing, with the exception of HealthMate Direct 2000. The rate relativity factor for HealthMate Direct 2000 was calculated by taking the factor from the previous filing's HealthMate Direct 1500 and multiplying it by a rate adjustment factor developed in Attachment I of last year's revision to the rate filing.

The final stage in the rate development was to apply age/gender, individual and family rate, and rate-tier normalization factors to the base rates, by product and pool, and to incorporate Organ Transplant rates, in order to produce the monthly subscription rates. These calculations and results are presented in the schedules contained in Sections I and II for Basic (Pool I) and Preferred (Pool II) respectively.

Q. In your description of the basic approach taken to develop the required rates, you state that the starting point was base period incurred allowed claims, as opposed to base period incurred claims expense amounts. Please describe the difference and why allowed claims were used instead of claims expense.

A. The difference between allowed claims and claims expense is attributable to deductibles, coinsurance, and co-payments amounts, which are the responsibility of the subscriber. Claims expense reflects the benefit payment amounts under the terms of the particular product. Allowed claims include both claims expense amounts and subscriber cost-sharing amounts. It is the total cost of covered services under the provider contracts maintained by Blue Cross prior to the determination of subscriber cost-sharing, versus Blue Cross benefit payments.

Claims expense varies widely from one product to another if the benefit provisions differ significantly, and products with relatively large deductibles have claims expense levels which are skewed during the course of a year, due to deductible accumulations. In addition, the year-to-year increase in claims expense is leveraged by fixed dollar cost-sharing – such as deductibles and per service copayments. The impact of these characteristics is exacerbated when the mix of subscribers by product is changing. Allowed claims, by contrast, do not vary in these ways – other than the relatively more modest impact that benefit provisions

may have on the overall level of utilization of services, which we refer to as the impact of "benefit richness."

In the rate development, base period allowed claims were used as the starting point in order to deal most effectively with these issues.

Q. With regard to the use of allowed claims as the starting point, you also state that these allowed claims were adjusted to a consistent product basis, in particular to the Direct Blue Standard product. How and why was this adjustment to the Direct Blue Standard product made?

A. Adjustments to the prior Direct Blue Standard product were made by applying benefit richness factors and contractual adjustment factors to the allowed claims PCPM for each of the three prior products. Milliman provided the benefit richness factors to Blue Cross for this purpose. These factors are outlined in their letter addressed to me dated November 6, 2006 and marked as Blue Cross Exhibit 4 for identification. These benefit richness factors reflect the differences in levels of utilization and mix of services that we would expect among the various products, for a given covered population. The differences in utilization and mix of services are attributable to the incentives created by the benefit features of the particular product. The factors we provided have been normalized to a value of 1.000 for Standard. The contractual adjustment factors are calculated on Schedule 52.

This adjustment to a consistent product basis was made so that allowed claims by product could be composited within each pool, and so that migration data could be applied to develop allowed claims PCPM for each of the products that exist today. This process is consistent with how the initial rates for these products were developed last year.

Q. You refer to migration data into the current products. How and why was this developed?

A. As of April 2006 each Class DIR subscriber was enrolled under a new product. In last year's rate filing we had to make assumptions about where everyone would end up. However, for this year's filing the migration percentages are the actual migrations that occurred between March 2006 and June 2006 and are documented in the schedules contained in Sections V and VI.

This migration data was incorporated into the rate development because of the change in products, coupled with the substantial differences in allowed claims PCPM among the previous products within each pool. Projected claims expense levels for the current products are therefore affected, as well as the level of overall required income produced.

Q. Later in your description of the basic approach taken to developing the required rates, you indicate that benefit adjustment factors were applied to projected allowed claims to produce projected incurred claims expense. Please explain how the factors to accomplish this were developed.

A. We used net to allowed, contractual adjustment, and benefit richness factors to produce the benefit adjustment factor for each product. The benefit richness factors were supplied by Milliman. Blue Cross used a re-adjudication process to develop net to allowed factors, which reflect the ratio of claims expense to allowed claims for the benefits under a given product. This methodology is consistent with last year's filing and similar to that employed by Blue Cross in the past to estimate the impact of changes in benefit costs. The first step in the calculation of non-drug net to allowed factors for the HealthMate Direct 400 and HealthMate Direct 2000 plans and in the calculation of total net to allowed factors for HealthMate for HSA 3000 and

HealthMate for HSA 5000 plans was to project incurred allowed claims for Class DIR from a calendar year 2004 and calendar year 2005 measurement period to the twelve month rate projection period ending March 31, 2008. For the calculation of the drug net to allowed for the 20%/25%/50% Coinsurance plan only calendar year 2005 allowed claims were used. Drug claims from this measurement period were projected to the twelve month rate period ending March 31, 2008. A shorter measurement period for drugs was used partly in recognition of the greater statistical credibility of drug versus medical experience and partly because shifts in generic use and formulary changes make earlier experience less relevant. For both drugs and non-drugs we used a measurement period ending December 31, 2005 for this analysis so that the underlying detailed claims would be largely run out by the time of the analysis. Both the measurement period and the projected rate year allowed claims were then re-adjudicated, with the results for the measurement period used for validation and calibration purposes. Following this process, each of the products were re-adjudicated using the same procedure. The key benefit provisions that were recognized for each for the re-adjudications are shown in the schedules contained in Section VII.

Q. Toward the latter part of your description of the basic approach taken to developing the required rates, you describe the determination of experience-adjusted composite required base rate amounts PCPM by pool. Is the composite of these Basic (Pool I) and Preferred (Pool II) amounts simply the required average rate PCPM for the entire Class DIR?

A. Yes, that is correct.

Q. You indicate that Blue Cross elected to target an 8.9% rate increase for Basic (Pool I) in adjusting rate relations between pools. Is that correct?

A. Yes.

Q. If Blue Cross had elected to use 100% of the experience difference in developing the rates, how would the required rates have differed from those filed?

A. If the full experience difference had been reflected, Preferred (Pool II) rates would have been about 12% lower, and Basic (Pool I) rates would have been about 5% higher.

Q. If, alternatively, Blue Cross had elected to use none or 0% of the experience difference in developing the rates, how would the required rates have differed from those filed?

A. If none of the experience difference had been reflected, Preferred (Pool II) rates would have been about 2% higher, and Basic (Pool I) rates would have been about 1% lower.

Q. From an actuarial perspective, do you believe it is appropriate to reflect some or all of the experience difference between pools in developing the required rates?

A. From an actuarial perspective, I believe that doing so is warranted and appropriate. Although the two pools are part of the same Class DIR, they have separate eligibility requirements; and as a result the two pools have different risk characteristics and different experience levels.

Q. Near the end of your description of the basic approach taken to developing the required rates, you indicate that the final step in calculating base rates was to apply product rate relativity factors to the pool experience-adjusted composite required base rate amounts PCPM. Please explain how these factors were developed.

A. The product rate relativity factors used in this filing are the same product relativity factors underlying the current rates.

Q. At the very end of your description of the required rate development, you indicate that the monthly subscription rates include a rate component for Organ Transplants. Why are there separate rates for this coverage, and how were they determined?

A. Blue Cross purchases 90% reinsurance coverage for Organ Transplants, through BCS Insurance Company. As a result, the rate development for Organ Transplants is based on current reinsurance rates for this coverage, grossed up to a 100% level, trended to the rate period, and adjusted for certain retention components (investment income credit and reserve/tax contribution). The resulting required rates are then added into the final monthly subscription rates. The details behind the Organ Transplant components are illustrated in Section IX.

Q. Returning back to the overall rating methodology, were there any mandated benefits or policy decisions which have or will affect the Class DIR product options? And if so, how were these reflected in rating?

A. There have been several mandated benefits or policy decisions since the time of the last approved rate filing for Class DIR which have an effect on the premiums for Class DIR. These are outlined in Section IV.

Q. What has Blue Cross done to incorporate the legislation to cover part-time students to age 25?

A. While we do believe that this legislation will increase Direct Pay PCPM costs, our filing does not include any provision for such impact as we do not believe we can estimate its impact with sufficient accuracy to include in our rate development. This legislation (as would any future expansion of dependent coverage under group plans) increases required DIR rates because many of the lowest cost risks become eligible for group coverage and leave

the DIR risk pool. Currently individual contract holders ages 20-25 represent about 13% of our Direct Pay subscribers. Eliminating these lower cost risks would necessitate about a 6% rate increase. We suggest that if the Legislature is going to entertain future expansions of dependent coverage that such proposals also incorporate some means of holding Direct Pay subscribers harmless as regards the rate impact that will flow from migrating healthy young enrollment from the DIR rolls to group coverage. We believe a Pay or Play assessment on group writers who don't also participate in the Direct Pay market would be a good way of financing a rate subsidy to immunize DIR subscribers from a negative impact.

Q. Please turn to Section IV and describe for us the schedules that are contained in this section.

A. Section IV starts with Schedule 24. Schedule 24 is titled "Calculation of Claims Impact of Benefit Mandates, New Technology, and State Assessments" and illustrates the different benefit mandates, new technologies, and assessments that have an impact on the rates being filed for Class DIR. The total impact of these is also shown at the bottom. The detail behind each of these calculations is supplied in Schedules 25 through 31. The total impact of these elements is 1.18% to claims expense.

Q. Can you please run through each of the schedules 25 through 31 that you just mentioned and describe those for us?

A. Yes. Schedule 25 is titled "Calculation of Claims Impact of Hearing Aid Mandate Effective July 14, 2006." We have used experience across all of our Commercial population to estimate DIR claim costs. We believe that the claim frequency for these mandated benefits is too low for DIR experience to be creditable on its own. The overall impact calculated for this mandate is .02% to claims.

Schedule 26 is titled "Calculation of Claims Impact of Cranial Prosthetics Mandate Effective January 1, 2007". We have again used experience across all of our Commercial population to estimate DIR costs. The overall impact calculated for this mandate is .02% of projected claim costs.

Schedule 27 is titled "Calculation of Claims Impact of Smoking Cessation Mandate Effective January 1, 2007". For the reasons noted above we used experience across all of our Commercial population to estimate DIR costs. The overall impact calculated for this mandate is .05% of projected claims.

Schedule 28 is titled "Calculation of Claims Impact of New Human Papillomavirus (HPV) Vaccine for Ages 19 and Older." Using published utilization projections and costs associated with this immunization, we have calculated an overall impact of 0.08% to the Class DIR claims due to this new vaccine. While the state immunization program covers this immunization for children through the age of 18, there will be an additional cost incurred by Blue Cross to cover immunizations for females aged 19 and older.

Schedule 29 is titled "Calculation of Claims Impact of Child Immunization Assessment". This assessment is made as a percentage of premium at an invoice rate of .65%. This translates into an overall impact on Class DIR of .65% when applied to projected claims expense.

Schedule 30 is titled "Calculation of Claims Impact of Adult Immunization Assessment". This assessment will be made as a percentage of premium at an estimated rate of .10%, which we translate into a factor equal to .10% of projected claims.

Schedule 31 is titled "Calculation of Claims Impact of CEDARR, CIS, and Home Services". This assessment will be made as a percentage of premium at an estimated rate of .255%. This has an overall impact on Class DIR projected claims of .26%.

Q. Have State Assessments of the above sort been included in Class DIR rates in the past?

A. No.

Q. Why is that?

A. The assessments for Adult Immunization and for the State's CEDARR, CIS, and Home Services costs were newly imposed this year. The Child Immunization program has existed for some time but was expanded this year. In the past as a matter of policy we had not been assessing these costs to the DIR line but instead have been absorbing them in our Group rating.

Q. Why are they being included with this filing?

A. The size of these assessments has grown significantly and we are concerned that they may continue to grow in the future. As such we don't think we can continue to absorb these costs in our other lines without threatening our competitive standing in those market segments. Accordingly our policy will now be to build into our DIR rates any assessment levied on Blue Cross based on DIR premiums. We believe that the only appropriate way of insulating DIR from these costs (if indeed the Legislature wishes to so insulate DIR) is to define future bases for assessments in such a way as to exclude DIR business.

IV. REQUIRED CLASS DIR BASIC (POOL I) AND PREFERRED (POOL II) MONTHLY SUBSCRIPTION RATES

Q. Please turn to Schedule 34 of Blue Cross Exhibit 3 and describe that schedule.

A. Schedule 34 is entitled "Projection of Standard Basis Incurred Allowed Claims per Contract Month for April 1, 2007 Billing Cycle for Direct Blue Standard." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the "Projected Standard Basis Incurred Allowed Claims PCPM" for Basic (Pool I). Calculations are documented in the footnotes.

Q. How does Schedule 34 compare with Schedules 35 and 36?

A. Schedules 35 and 36 are comparable in nature. They both also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to Direct Blue Economy and HealthMate Direct 2000, respectively, whereas Schedule 34 applies to Direct Blue Standard.

Q. On a column-by-column basis, would you explain what is contained in Schedules 34 through 36? Please note any relevant differences among them.

A. The first and second columns of each of these schedules show base period "Incurred Allowed Claims" for each of the respective products. As indicated in the applicable footnotes, and as I indicated earlier in my testimony, allowed claims were tabulated prior to the application of deductibles, coinsurance, or copayments. We used a base period for tabulating these allowed claims, and for the contract months underlying Column (2), of April 2005 through March 2006. Incurred allowed claims amounts for this base period reflect actual payments through August 2006, adjusted to a fully complete basis.

A difference among the three schedules occurs with regard to professional services – Surgical/Medical and Major Medical – and with regard to Preferred Rx. All line of business rows (e.g. Inpatient, Outpatient, etc.) are shown and contain values for Columns (1) and (2) for Direct Blue Standard in Schedule 34. For Direct Blue Economy in Schedule 35, no values are shown in Column (1) for either Major Medical or Preferred Rx, because these services are not covered under the prior Direct Blue Economy package. In order to accommodate this, "Incurred Allowed Claims PCPM" values are imputed in Column (2) for Major Medical and Preferred Rx services. The bases used for estimating these missing values are documented in the footnotes to Schedule 35. For HealthMate Direct 2000 in Schedule 36, as indicated in the footnotes, all professional services are shown in the Surgical/Medical row, since there is not a separate Major Medical line of business under the HealthMate product package.

Columns (3) and (4) contain factors used to adjust the "Incurred Allowed Claims PCPM" in Column (2) to the Direct Blue Standard product level in Column (6).

Column (3) contains the "Contractual Adjustment Factor". This factor reflects the difference in Blue Cross' provider contractual payment levels and dependent coverage between the product addressed by the particular schedule and Direct Blue Standard. In the case of Schedules 34 and 35, all Contractual Adjustment Factors are 1.000, since both Direct Blue Standard and Direct Blue Economy are administered under Blue Cross' Classic provider agreements and dependent coverage policies. For Schedule 36, factors reflecting the provider contractual payment level and dependent coverage relationships between the HealthMate Coast to Coast and the Classic provider agreements are incorporated. As indicated in the footnotes, these factors are developed in Schedule 52.

Column(4) contains the "Benefit Richness Factor". This factor, as I described earlier in this testimony, reflects the difference in utilization and mix of services anticipated for the product addressed by the particular schedule vs. Direct Blue Standard. The differences in utilization and mix of services are attributable to the incentives created by the benefit features of the particular products. The factors used by us in this filing were provided by Milliman, and are documented in a letter from Jay Dunlap and George Berry of Milliman addressed to me, dated November 6, 2006 and marked as Blue Cross Exhibit 4. In Milliman's development of these factors, they were normalized to a value of 1.000 for Direct Blue Standard. For this reason, the values shown in Schedule 34 for Direct Blue Standard are 1.000, whereas the corresponding factors in Schedules 35 and 36 are less than 1.000 since these products have leaner benefits than Direct Blue Standard.

Column (5) shows the "Projection Factors" used to incorporate trends into the projection of allowed claims PCPM for the rate period. The "Projection Factors" are developed in Schedule 60, as indicated in the footnotes. Consistent "Projection Factors" are used in all three schedules. Note that in regard to Column (5) for Direct Blue Standard and Direct Blue Economy, combined factors are used for Surgical / Medical and Major Medical.

Q. You state that Schedules 34 through 36 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are Schedules 39 through 41.

Q. Are there any differences between Schedules 39 through 41 and Schedules 34 through 36, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

A. No. The same calculations are carried out, and the same issues are present.

Q. With regard to the "Contractual Adjustment Factors" shown in Column (3) of these six schedules, you refer to their development in Schedule 52. Could you please turn to Schedule 52 and describe that schedule?

A. Schedule 52 is entitled "Calculation of Non-Drug Contractual Adjustment Factors." It applies to Basic (Pool I) and Preferred (Pool II). The "Contractual Adjustment Factor" values, as I just described, reflect the average difference in Blue Cross' provider contractual payment levels and dependent coverage between the HealthMate Coast to Coast and Classic provider agreements. Different provider payment levels are applicable under those two provider agreements, primarily for out-of-state claims. For in-state claims, provider payment levels for Blue Cross contracting providers differ between the HealthMate Coast to Coast and the Classic provider agreements with respect to lab and x-ray services. Also, under HealthMate Coast to Coast, full-time students are covered to age 23. Under Classic, dependents were only covered to age 19. Please note that this difference in dependent coverage is mutually exclusive from the new state mandate to be effective on January 1, 2007 which will require insurers to cover full-time and part-time students up to age 25.

Schedule 52 shows the development of the "Contractual Adjustment Factors" needed to adjust allowed claims for these differences in provider payment levels and dependent coverage between the HealthMate Coast to Coast provider agreement level and the Classic provider agreement level. The "Contractual Adjustment Factor" values are determined so that a value of 1.000 applies to the Classic agreement. Schedule 52 then develops the corresponding values for HealthMate Coast to Coast. Calculations are documented in the footnotes to Schedule 52.

Q. Please describe what is contained in Schedule 52.

A. The columns of Schedule 52 contain values for Inpatient, Outpatient, Surgical/Medical, and Total Non-Drug. Line 1 shows the distribution of projected allowed claims by line of business; this is used to calculate composite non-drug totals for the three lines of business. Lines 2 through 4 calculate the "Contractual Adjustment Percentages" for the lines of business. Line 2 shows the proportion of allowed claims for each line of business that is out-of-state, and Line 3 displays the corresponding difference in contractual payment levels. Line 4 shows the Contractual Adjustment Percentage for out-of-state payment differences between HealthMate Coast-to-Coast Products and Classic Direct Products. Lines 5 through 7 calculate the adjustment percentage for the differences in reimbursement rates for in-state lab & x-ray services between HealthMate and Classic provider agreements. Line 8 represents the impact of differences in dependent coverage between HealthMate and Classic products. As mentioned in footnote (H), HealthMate products cover full-time students as dependents on a family policy up to age 23, whereas the comparable coverage on Classic Direct products was covering dependents only up to age 19. The remaining lines show the computational steps, and are documented in the footnotes.

Q. With regard to the "Utilization / Mix Trend Factors" shown in Schedule 60, you state that they were developed from an analysis by your staff of historical trends for Class DIR. Please describe the nature of this analysis.

A. The utilization / mix trend analysis undertaken by my staff focused on inpatient hospital days for the Hospital Inpatient line of business, and on allowed claims PCPM that have been adjusted to a common price level, namely July 2003, for the Hospital Outpatient and Surgical / Medical lines of business. For Preferred Rx, allowed claims PCPM without any price adjustment were analyzed.

The data points used in this analysis were 12-month moving values, beginning with the period ending June 2004. Twenty-five data points, which equates to three years of experience, were chosen to provide a meaningful measurement period and to be consistent with previous rate filings. Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, a statistical technique for quantifying trend levels. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points using the most recent 13 or more data points, with a minimum R-squared value of 0.70 to help assure reasonable fit to the data points.

The annual trend indicated by the least squares line producing the best fit under this procedure is then selected as the basis for the trend assumption, provided the result is acceptable actuarially. Adjustment or modification to this result, or substitution of an alternative assumption, may occur if it is not reasonable or appropriate in our actuarial judgment.

Q. Could you please elaborate on the least squares calculation method?

A. This is the method that has been utilized and presented in past rate filings for quantifying trends. It has been discussed extensively in previous rate hearings. Briefly, by

plotting a number of historical observations on a graph, the average change over a specified time period may be calculated using a statistical technique referred to as the method of linear least squares.

For the observations plotted on the graph, a general trend – either up, down or neutral – may be observed by visual inspection of the line plotted on the graph. That is, it may be possible to detect that a succession of points on the graph are generally higher than, lower than, or about the same as the previous points. The method of linear least squares quantifies this average change in values over time by use of a statistical computation.

The principle of least squares states that the line of best fit to a series of observed values is the line where the sum of the squares of the deviations (the differences between the line and the actual values) are minimal or the "least" possible. While one may attempt to draw a straight line through the observations by visual interpretation to denote a trend, the method of least squares obtains that minimum sum of squared deviations necessary to give a best linear fit of the data.

Q. Would you please describe the methodology in terms of the number of data points used in order to find the best fit?

A. Yes. We considered a total of 25 monthly 12-month moving data points. The number of data points consisting of the most recent 13 or more points that provide the best fit was calculated, as I just described. There was no discretion in the selection of the number of data points; it was mathematically determined. There is only one possible best fit, which is the number of data points that produces the line with the highest R-squared value.

Once the number of 13 or more of the most recent data points that provides the best fit is found, the trend indication based on those data points is what we utilize in the rate

calculations, provided that the "best fit" is actuarially acceptable. A trend line within an R-squared value of 0.70 or higher is generally considered statistically acceptable to us; however, information to the contrary, such as a non-credible experience base or an erratic or biased pattern of data points, in addition to a low R-squared value, or when the result is unreasonable, may provide reasons to utilize actuarial judgment in trend determination.

Q. In your opinion, is the use of less than 13 of the most recent monthly 12-month data points appropriate as an actuarial method for quantifying utilization / mix?

A. No. In my opinion, fewer than 13 of these points do not provide sufficient historical data from which to measure an underlying trend level.

Q. Does Blue Cross consistently use at least 13 monthly 12-month data points in the calculation of the best fit whether or not it provides to Blue Cross a higher rate than some other number of data points?

A. Yes, provided the best fit produces results that are actuarially acceptable.

Q. Is a good fit a valid measure of an underlying trend?

A. In the absence of information to the contrary, it normally is a reasonable indicator.

Q. As a matter of statistical principle, is it correct that the better the fit, the greater the validity of the trend measurement?

A. Yes.

Q. Is the choice of the best fit within a displayed number of data points discretionary?

A. No. There is only one best linear fit. One cannot pick and choose best fits.

Q. Would you briefly describe what "utilization" is and what "mix" is as these terms have been used in the various schedules and in your testimony?

A. "Utilization" refers to the rate of use of covered services by subscribers. "Mix" of services refers to the change in distribution of claims amounts by factors affecting the amounts such as changes in the types of claims, procedures and services performed, providers rendering service and other changes in the types of services used as opposed to the rate of use.

Q. Were there any adjustments made to the data used for the trend analysis you just described?

A. Yes. Surgical/Medical experience for Direct Blue Economy was excluded, since that product package did not include coverage of Major Medical services. As a result, allowed claims for overall Surgical/Medical services are not complete for Direct Blue Economy subscribers. Also, certain modest adjustments were made to the allowed claims PCPM under Preferred Rx, in order to reflect global changes in the pricing, quantities, and over-the-counter dispensing of certain specific prescription drugs. Lastly, Organ Transplant claims were excluded, since coverage is provided through a separate reinsured arrangement.

Q. Are you satisfied with the appropriateness of these adjustments to the data?

A. Yes.

Q. Please turn to Schedule 61, and describe what is contained in that schedule. Schedule 61 is entitled "Hospital Inpatient: Historical Days per 1,000 Members and Utilization Trends." This schedule contains a graph displaying annual inpatient days per 1,000 members for 25 monthly 12-month moving periods or data points, for Class DIR. The data

points begin with the 12-month period ending June 2004 and continue through the 12-month period ending June 2006. These data points have been adjusted for shifts in products and pools.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, as I described earlier. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent 13 data points or more). As shown in Schedule 61 the line with the best fit is based on the most recent 25 data points; however it has an R-squared value of only 0.257. Due to the low R-squared value, which is well below the Blue Cross standard minimum of 0.70, actuarial judgment was used in setting the projection assumption for inpatient hospital days per 1,000 members. Blue Cross chose 0.00% as its annual projection assumption for inpatient days. In doing so, it recognized the cyclical pattern over time of the observations in the graph in Schedule 61. This annual trend assumption is documented in the footnotes contained in Schedule 60.

Q. Please turn to Schedule 62, and describe what is contained in that schedule.

A. Schedule 62 is entitled "Hospital Outpatient: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending June 2004 and continue through the 12-month period ending June 2006. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or "depriced," to July 2003, so that intervening price increases have been removed from the allowed claim PMPM values used. These data points have also been adjusted for shifts in products and pools.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing Schedule 61 earlier. Similarly, following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in Schedule 62, the line with the best fit is based on all data points, which has an R-squared value of 0.887 and represents a calculated annual trend of 6.15%. Since the R-squared value met our minimum criteria of 0.70, and there was no information to the contrary, 6.15% was selected for Outpatient Hospital. This annual trend assumption is documented in the footnotes contained in Schedule 60.

Q. Please turn now to Schedule 63, and describe what is contained in that schedule.

A. Schedule 63 is entitled "Surgical/Medical: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending June 2004 and continue through the 12-month period ending June 2006. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or "depriced," to July 2003, so that intervening price increases have been removed from the allowed PMPM values used. These data points have also been adjusted for shifts in products and pools, and they exclude experience for Direct Blue Economy. Note that "Surgical/Medical," as the term is used here, includes "Major Medical" allowed claims under Direct Blue Standard. Thus, the data underlying this analysis includes the overall allowed claims for professional services for Direct Blue Standard and HealthMate Direct 2000.

Again, trend lines were fit to a number of sets of data points utilizing the method of linear least squares. Following standard Blue Cross procedures, calculations were made to

determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in Schedule 63, the line with the best fit is based on 13 data points, which has an R-squared value of 0.894 and represents a calculated annual trend of 3.36%. Because of recent information pertaining to the release of new biotech drugs, as well as the expansion of the kinds of diseases that some of the existing biotechs are being approved to treat, we have chosen to add 1.0% to this calculated trend. Specific examples of these drugs include Tysabri, which is utilized for treatment of Multiple Sclerosis and was re-released in July 2006, and Avastin, which is an oncology drug currently approved for use in treating colon cancer and which is likely to be expanded for use in certain types of breast and lung cancers with treatment costs running from $50,000 to $100,000 a patient. Remicade is another drug that is used for a variety of afflictions including rheumatoid arthritis and Crohns Disease, which recently received approval for use in treating ulcerative colitis. Additionally, Lucentis is an effective therapy for wet macular degeneration that was approved in June 2006. Annual treatment costs with this drug run in the neighborhood of $20,000-$25,000 per member per year. It is also expected that other, high cost biotech drugs and devices will be approved by the FDA during the rate year. Since the experience being utilized to develop the trends does not contain the impact from these biotechs, the overall Surgical/Medical trend being utilized for this filing is 4.36% and is documented in the footnotes of Schedule 60.

Q. Please turn to Schedule 64, and describe what is contained in that schedule.

A. Schedule 64 is entitled "Preferred Rx: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the

12-month period ending June 2004 and continue through the 12-month period ending June 2006. These values have not been depriced, so their trends reflect both price and utilization/mix.

The line exhibiting the best fit produced an annual trend of 5.14%. It consisted of all data points, with an R-squared value of 0.975. Actuarial judgment was exercised by Blue Cross, however. Despite the high R-squared value, the calculated value of 5.14% seems incredibly low to us compared to what we see in our Commercial lines and what is reported in the various inter-company surveys we have monitored. We believe that a 10% trend factor (which is consistent with how we are rating Group business) is more reflective of the experience we are apt to see going forward and accordingly we are substituting that factor for the calculated amount. We would point out that in last year's filing the least squares calculated value was a trend factor of 15.3%, but, because it seemed unreasonable, we chose to override the calculated value and utilized a trend factor of 10%. This annual trend assumption is documented in the footnotes contained in Schedule 60.

Q. Would you turn now to Schedule 65, and describe what is contained in that schedule?

A. Schedule 65 is entitled "Point Values Utilized in Development of Trends." This schedule displays the inpatient days per 1,000 members and allowed claims PMPM values utilized to calculate trends in Schedules 61 through 64. The first column shows the dates applicable to each of the 25 monthly 12-month periods observed. Opposite each date are the values reflected in the various graphs set forth in Schedules 61 through 64 for each of the applicable lines of business.

Q. Please turn now to Schedule 33 and describe that schedule.

A. Schedule 33 is entitled "Calculation of Projected Incurred Claims Expense per Contract Month after Migration for Current Products for April 1, 2007 Billing Cycle." It uses the "Projected Standard Basis Incurred Allowed Claims PCPM" amounts from Schedules 34 through 36 to develop the projected incurred "Claims Expense PCPM" after migration for each of the four current products under Basic (Pool I). It accomplishes this by applying subscriber migration data to map subscribers and their respective projected allowed claims PCPM from each of the three previous products into the four current product options. Then, benefit adjustment factors and claims savings factors reflecting benefit cost levels under each of the current products are applied to produce the projected incurred "Claims Expense PCPM" after migration values for the rate period. Calculations are documented in the footnotes.

Q. Would you please explain each of the columns in Schedule 33?

A. Column (1) contains the "Projected Standard Basis Incurred Allowed Claims PCPM" amounts for the rate period. The values contained in it were developed in Schedules 34 through 36, for each of the three respective prior products. Column (2) contains the corresponding "Base Period Contract Months" for each of the three prior products (documented in the footnotes to the respective Schedules 34 through 36).

Columns (3) through (6) show the contract months by prior product from the base period, mapped to each of the current products. The specific migration data is documented in the footnotes. As I indicated earlier in my testimony, the migration percentages being utilized were determined from the actual enrollment shift that occurred with the introduction of the current products in April of 2006.

Using the "Projected Standard Basis Incurred Allowed Claims PCPM" by existing product and the mapping of contract months into the current products, Blue Cross calculated the

resulting projected incurred "Standard Basis Allowed Claims PCPM" after migration, which is shown in Column (7). It should be noted that the overall composite total projected Standard basis incurred allowed claims PCPM is the same, before and after migration.

Column (8) contains the "Benefit Adjustment Factor" for each of the current products. Each product's "Benefit Adjustment Factor" reflects the value of the benefit costs after subscriber cost sharing, or claims expense, under each of the current products relative to Direct Blue Standard allowed claims. As indicated in the footnotes, these factors are developed in Schedule 46.

Column (9) contains the "Claims Savings Factor" for each of the current products. The "Claims Savings Factors" represent the impact from making the policy changes that I mentioned earlier. These factors are developed in Schedule 43.

Q. You stated that Schedule 33 applies to Basic (Pool I) only. Is there a comparable schedule for Preferred (Pool II)?

A. Yes. It is Schedule 38.

Q. Are there any differences between Schedule 33 and Schedule 38, other than applying to Preferred (Pool II) versus Basic (Pool I)?

A. No. The same calculations are carried out, and the same issues are present.

Q. With regard to the "Benefit Adjustment Factors" shown in Column (8) of these two schedules, you refer to their development in Schedule 46. Could you please turn to Schedule 46 and describe that schedule?

A. Schedule 46 is entitled "Calculation of Benefit Adjustment Factors." It applies to Basic (Pool I) and Preferred (Pool II). The "Benefit Adjustment Factor" values, as I

just described, reflect the claims expense under each of the current products relative to Standard basis allowed claims. Schedule 46 shows the development of the "Benefit Adjustment Factors" needed to adjust the projected incurred "Standard Basis Allowed Claims PCPM" to projected incurred "Claims Expense PCPM" for each respective current product. Calculations are documented in the footnotes.

Q. Would you please explain each of the columns in Schedule 46?

A. Column (1) contains "Net to Allowed Factors" for each product. These factors, as I described earlier in my testimony, reflect the ratio of claims expense under a product, after subscriber cost sharing, to Standard product basis allowed claims. For the HealthMate Direct 400 and HealthMate Direct 2000 products, separate "Net to Allowed Factors" are included for drug vs. non-drug services, since Preferred Rx drug coverage is free-standing. For the two HealthMate for HSA products, composite "Net to Allowed Factors" are included, since prescription drugs are integrated with non-drug services under common deductible provisions. The "Net to Allowed Factors" for the various products and service components are developed and documented in Schedules 47 through 51, as indicated in the footnotes.

Columns (2) and (3) contain "Contractual Adjustment Factors" and "Benefit Richness Factors," respectively. These are factors that I described earlier in my testimony. The "Contractual Adjustment Factors" for non-drug services are developed in Schedule 52, and the "Contractual Adjustment Factors" for drug services are set to 1.000. The "Benefit Richness Factors" were supplied by Milliman.

Column (5) contains the resulting "Benefit Adjustment Factors." Composite values are calculated for drug and non-drug services combined in this column, for each product.

The drug vs. non-drug weights for calculating these composites are shown in Column (4) and documented in the footnotes.

Q. With regard to the "Net to Allowed Factors" shown in Column (1) of Schedule 46, you refer to their development and documentation in Schedules 47 through 51. Could you please describe generally the method used to develop these "Net to Allowed Factors"?

A. To determine Net to Allowed, the allowed claims for each Direct Pay member are "re-priced" to simulate members having each of the current plan designs. Claims for CY 2004 and CY 2005 are trended to the rate year 4/07-3/08, where each is run through this re-pricing process and are then combined. Net to Allowed calculations for prescription drug claims for the HealthMate 400 and HealthMate 2000 products are calculated separately and use only CY 2005, as prescription drugs are more stable than other medical claims and the more recent mix of generic, tier 2 brand, and tier 3 brand will yield a more current net to allowed. The prescription drug net to allowed calculations for the Healthmate for HSA 3000 and for the Healthmate for HSA 5000 products are incorporated into the medical net to allowed calculations, since prescription drug claims for these plans apply towards the deductible.

Q. Now please turn to Schedule 47 and describe that schedule.

A. Schedule 47 is entitled "Calculation of Non-Drug Net to Allowed Factor for HealthMate Direct 400 Plan." The "Net to Allowed Factor" values, as I have just described, reflect the ratio of claims expense under a product to allowed charges, where allowed charges are consistently measured on a Standard product basis.

Schedule 47 shows and documents the development of the "Net to Allowed Factor" for non-drug services for the HealthMate Direct 400 plan, applicable for both Basic

(Pool I) and Preferred (Pool II). It is needed to adjust projected incurred claims from an allowed claims basis to a claims expense basis under the HealthMate Direct 400 plan.

Q. Would you please explain each of the Lines in Schedule 47?

A. Line 1 shows the "Projected Incurred Allowed Claims" used in the development of the "Net to Allowed Factor" for non-drug services for the HealthMate Direct 400 plan. As indicated in the footnotes, the amount shown in Line 1 is the total non-drug allowed claims for Class DIR (excluding the Direct Blue Economy product, which does not cover the same scope of services) incurred during 2004 and 2005 and projected to the 12-month rate period beginning April 2007.

Line 2 shows the "Adjusted Net Amount" corresponding to the projected incurred allowed claims in Line 1. This "Adjusted Net Amount" reflects the net amount of claims expense, after subscriber cost sharing. As I generally described earlier in my testimony, it was developed by re-adjudicating the allowed claims in Line 1, reflecting the benefit provisions for non-drug services under the HealthMate Direct 400 plan.

Line 3 contains the "Net to Allowed Factor" for non-drug services for the HealthMate Direct 400 plan. It is calculated as the ratio of Line 2 to Line 1, as indicated in the footnotes.

Q. You also refer to Schedules 48 through 51, in addition to Schedule 47, as providing the development and documentation for the "Net to Allowed Factors" contained in Schedule 46. Please describe Schedules 48 through 51.

A. Schedule 47 develops and documents the "Net to Allowed Factor" for non-drug services for the HealthMate Direct 400 plan. The corresponding development is presented in Schedules 48 through 51 for non-drug services under the HealthMate Direct 2000

product, total services (drug and non-drug) under the HealthMate for HSA 3000 product, total services (drug and non-drug) under the HealthMate for HSA 5000 product, and drug services under the current 20%/25%/50% coinsurance Preferred Rx stand-alone product, respectively.

Q. Are there any differences between Schedules 48 through 51 and Schedule 47, other than applying to different product options?

A. No. Comparable re-adjudication calculations were carried out by Blue Cross, depending on the coverage (drug vs. non-drug vs. combined) and product benefit provisions. The calculations in the schedules are the same.

Q. You also refer to Schedule 43 in explaining column (9) of Schedule 33. Can you please turn to Schedule 43 and describe that schedule?

A. Schedule 43 illustrates the impact from the claims-saving changes that I have previously mentioned. The two claims-saving changes represent the introduction of the Managed Pharmacy Program and a Radiology Management Program. Schedule 43 develops factors for each current product. These programs are described more fully in Mr. Boyd's testimony.

Q. Can you please describe the columns in Schedule 43?

A. Column (1) contains the adjustment factor reflecting the introduction of the Managed Pharmacy Program. The factor is developed on Schedule 44.

Column (2) contains the adjustment factor for the Radiology Management Program. This factor is developed on Schedule 45.

Column (3) details the weights of claims expense between Non-Drug and Drug for each product.

Column (4) develops composite factors from multiplying column (1) times column (2). These are then composited into an overall factor for each product based on the Claims Weight in column (3).

Q. You referred to Schedule 44 and 45 in describing Schedule 43. Can you please turn to those schedules and describe those?

A. Yes. Schedule 44 is titled "Calculation of Preferred Rx Claims Impact Factor for Managed Pharmacy Program". It details the key cost control elements of our managed pharmacy initiative – each with a corresponding savings in drug claims. These savings are totaled in line 8 and sum to an expected savings equal to 3.9% of drug claims.

Schedule 45 is titled "Calculation of Claims Impact of Radiology Management Program Effective January 2008". It takes the savings estimated for our Commercial population and adjusts this to Class DIR. It then accounts for the fact that only 3 months of this rate period will be affected by this initiative. The savings anticipated to result from this initiative is .14% of claims.

Q. You mention that the impact is only .14% for the rate period because the program is only in effect for a partial year. Does this mean that the savings from this program will be greater in future years?

A. Yes. The overall savings expected is .57% on an annual basis. We would expect that this would be our rate of savings in subsequent rate periods.

Q. You have now described and explained the columns in Schedule 33, along with the various schedules supporting them. You have stated that Schedule 33 develops the projected incurred "Claims Expense PCPM" for each of the current products, after subscriber migration from the existing products.

Now I would like to turn to Section III of the rate filing and the development of the monthly base rates. Please turn to Schedule 18 and describe that schedule.

A. Schedule 18 is entitled "Calculation of Required Monthly Base Rates for April 1, 2007 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the "Required Monthly Base Rates" for each of the products under Basic (Pool I). Calculations are documented in the footnotes.

Q. On a column-by-column basis, please explain what is contained in Schedule 18.

A. Column (1) contains the number of contract months by product. It is used for weighting various amounts. As indicated in the footnotes, the values come from Schedule 33.

Column (2) shows the "Composite Required Monthly Base Rate" for Basic (Pool I). This value represents the projected overall average rate required from Basic (Pool I) subscribers. As indicated in the footnotes, this PCPM value is developed in Schedule 20.

Column (3) contains the "Rate Relativity Factors" for each of the current products. I mentioned previously in my testimony that these factors are the same as utilized in last year's approved filing.

Column (4) shows the Basic (Pool I) "Required Monthly Base Rate" for each of the four products. Calculations are documented in the footnotes. The "Rate Relativity Factors" in Column (3) are used to calculate the separate "Required Monthly Base Rates" for each product, consistent with the overall "Composite Required Monthly Base Rate" in Column (2).

Q. You state that Schedule 18 applies to Basic (Pool I) only. Is there a comparable schedule for Preferred (Pool II)?

A. Yes. It is Schedule 19.

Q. Are there are differences between Schedule 19 and Schedule 18, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

A. No.

Q. With regard to the "Composite Required Monthly Base Rate" in Column (2) of Schedules 18 and 19, you refer to their development in Schedule 20. Could you please turn to Schedule 20 and describe that schedule?

A. Schedule 20 is entitled "Calculation of Composite Required Monthly Base Rates for April 1, 2007 Billing Cycle." This schedule applies to both Basic (Pool I) and Preferred (Pool II). Its purpose is to display the calculation of the "Composite Required Monthly Base Rate," by pool. Calculations are documented in the footnotes.

Q. On a column-by-column basis, would you please explain what is contained in Schedule 20?

A. Column (1) contains the number of "Contract Months" for each pool, and Column (2) contains the "Projected Incurred Claims Including Mandates" for each pool. The sources of these values are documented in the footnotes. Note that the values in Column (1) are from Schedules 33 and 38, and the values in Column (2) are from Schedule 22.

Column (3) shows the "Required Loss Ratio, Full Experience Basis" for Basic (Pool I) and Preferred (Pool II). These ratios are the required loss ratios by pool that would be appropriate for use in developing the composite required monthly base rate if the separate experience for each of the two pools were to be fully used as the basis for developing the respective monthly subscription rates. The "Required Loss Ratios, Full Experience Basis" in Column (3) are developed in Schedule 22.

Column (4) shows the "Required Loss Ratio, Current Pool Rate Alignment Basis" for Basic (Pool I) and Preferred (Pool II). These ratios are the required loss ratios by pool that would be appropriate for use in developing the composite required monthly base rates if the current rate relationships or alignment for the two pools were to be fully maintained as the basis for developing the respective monthly subscription rates. The "Required Loss Ratios, Current Pool Rate Alignment Basis" in Column (4) are developed in Schedule 21.

Column (5) shows the "Required Loss Ratio, Experience Adjusted Basis" for Basic (Pool I) and Preferred (Pool II). These are required loss ratios by pool that are appropriate for use in developing the composite monthly base rates in order to incorporate partial recognition of the separate experience for each of the two pools, along with partial recognition of the current pool rate alignments. For Basic (Pool I), a 9% rate increase prior to Organ Transplant reinsurance rates being applied was targeted to produce the "Required Loss Ratio, Experience Adjusted Basis." The corresponding value for Preferred (Pool II) is then calculated so as to retain unchanged the composite value for the pools combined. The calculations involved in Column (5) are documented in the footnotes.

Column (6) contains the "Composite Required Monthly Base Rate" for Basic (Pool I) and Preferred (Pool II). These two PCPM values incorporate the new rate alignment between pools, consistent with partial recognition of the separate experience of the two pools, as reflected by the "Required Loss Ratios, Experience-Adjusted Basis" in Column (5). Note that the composite Class DIR required loss ratio remains unchanged through this rate re-alignment process.

Q. With regard to the "Required Loss Ratios, Full Experience Basis," you refer to their development in Schedule 22. Could you please turn to Schedule 22 and describe that schedule?

A. Schedule 22 is entitled "Calculation of Required Loss Ratio on Full Experience Basis for April 1, 2007 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the "Required Loss Ratios, Full Experience Basis" for each of the two pools. Calculations are documented in the footnotes.

Q. On a column-by-column basis, would you explain what is contained in Schedule 22?

A. Column (1) of Schedule 22 shows the contract months for Basic (Pool I) and Preferred (Pool II).

Column (4) shows the projected claims expense PCPM including the impact of state benefit mandates, new technologies, and assessments for each of the two pools. This is the product of Columns (2) and (3). The sources of these values are documented in the footnotes.

Column (5) contains the "Administrative Expense PCPM" for the rate period. As indicated in the footnotes, the value contained in Column (5) is developed in Schedule 54.

Column (7) contains the "Investment Income Credit PCPM" amounts. The investment income credit is the amount by which required subscription income is reduced due to anticipated earnings from invested funds.

The investment income credit is calculated by looking at three values that generate funds used to produce investment earnings, namely, the reserve level of the Class in question, prepaid subscriptions, and claim reserves. These amounts, after adjusting for only those funds that will be available for investment, are used to generate earnings. Based on a

projection of such amounts, a determination was made of the appropriate investment income credit factor, expressed as a percent of projected incurred claims and administrative expense. This calculation assumed long-term portfolio rates of return of 4.3% for 2007 and 4.4% for 2008, and 3.8% as the short-term portfolio rates of return during the time period involved, producing the investment income credit factor of 0.41% indicated in the footnotes to Schedule 22. This investment income credit factor was then used to calculate the "Investment Income Credit PCPM" shown in Column (7) of Schedule 22.

Column (8) contains the "Contribution to Reserve / Federal Tax Liability PCPM" values for the rate period. The reserve contribution and tax liability component is the amount requested by Blue Cross to include in the Class DIR subscription rates in order to contribute to the building and maintenance of reserves maintained by Blue Cross for the protection of its subscribers.

The factor used to calculate Column (8) is based on the requested contribution to reserve as a percentage of income plus one quarter of the amount for federal income taxes. Thus, in this case, the reserve contribution of 2% requires 0.5% for federal taxes (20% of the pre-tax gain). The combined contribution to reserve and federal tax PCPM is then calculated using a factor of 0.975.

The remaining columns in Schedule 22 are calculated using the values I just described. These calculations are documented in the footnotes. Column (10) then contains the "Required Loss Ratios" calculated for Basic (Pool I) and Preferred (Pool II), on a full experience basis. That means that the Basic (Pool I) value reflects the projected required loss ratio based fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

Q. With regard to the "Administrative Expense PCPM" shown in Column (5) of Schedule 22, you refer to its development in Schedule 54. Could you please turn to Schedule 54 and describe that schedule?

A. Schedule 54 is entitled "Calculation of Administrative Expense per Contract Month for April 1, 2007 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of this schedule is to weight together Blue Cross' administrative expense PCPM amounts for 2007 and 2008 from Schedule 55, to produce an appropriate amount for the April 1, 2007 billing cycle.

Q. Would you please turn to Schedule 55 and explain what that is?

A. Schedule 55 is entitled "Calculation of Calendar Year 2007 and Calendar Year 2008 Administrative Expense per Contract Month." It applies to both Basic (Pool I) and Preferred (Pool II). Schedule 55 displays the calendar year 2007 and 2008 administrative expense budget amounts, in aggregate and PCPM. These projections are based on methodology that is explained in the testimony of Mr. Boyd.

Q. Please turn back to Schedule 22. In your testimony regarding Column (8) of this schedule, you described the nature of the "Contribution to Reserve / Federal Tax Liability PCPM" and its calculation. You also indicate that a factor of .975 was used, in order to produce an after-tax contribution to reserves of 2% of subscription income. Is that correct?

A. Yes.

Q. What is the reserve status of Class DIR?

A. The Class DIR reserve position at September 30, 2006 was $(7,706,027), or (1.61) months in reserve. The Class DIR reserve position at March 31, 2007 is projected to be approximately $(7.5) million. The Class DIR reserve position at March 31, 2008 is projected to

be approximately ($6.3) million assuming income at the rates proposed by Blue Cross in this filing. These reserve positions are indicated on a Statutory Accounting Principles (SAP) basis and assume no unrealized capital gains or losses.

Q. What is the corporate reserve status of Blue Cross?

A. Blue Cross' reserve position at September 30, 2006 was $364,441,705, or 2.73 months in reserve, on a SAP basis.

Q. Please turn back to Schedule 20. In your testimony pertaining to Schedule 20, you describe three required loss ratio bases. Is that correct?

A. Yes.

Q. The first of these three required loss ratio bases you describe is the "Full Experience Basis" in Column (3), which you describe in your testimony pertaining to Schedule 22. Is that also correct?

A. Yes.

Q. The second of these three required loss ratio bases you describe is the "Current Pool Rate Alignment Basis" in Column (4), which you indicate is developed in Schedule 21. Is that correct?

A. Yes.

Q. Please turn to Schedule 21 and describe that schedule.

A. Schedule 21 is entitled "Calculation of Required Loss Ratios on Current Pool Rate Alignment Basis for April 1, 2007 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the "Required Loss Ratio, Current Pool Rate Alignment Basis" for each of the two pools. Calculations are documented in the footnotes.

The overall Class DIR "Required Income PCPM" is developed in Schedule 22. The same overall Class DIR "Required Income PCPM" is preserved in Schedule 21. The respective amounts by pool, however, differ between Schedule 22 and 21. In Schedule 22, the "Required Income PCPM" amounts by pool directly reflect the separate experience of each pool. Schedule 21 develops "Required Income PCPM" amounts by pool which reflect the current alignment of rates by pool, rather than pool experience. In both cases – Schedules 22 and 21 – the composite average "Required Income PCPM" must remain the same.

Q. On a column-by-column basis, would you explain what is contained in Schedule 21?

A. Column (1) of Schedule 21 shows the contract months for Basic (Pool I) and Preferred (Pool II). Column (2) shows the "Projected Incurred Claims Including Mandates" amounts for each of the two pools. The sources of these values are documented in the footnotes.

Column (3) contains the composite "Required Income PCPM" amount for Class DIR as a whole. This amount is developed in Schedule 22, which I described earlier in my testimony.

Column (4) contains the "Present Rate Income PCPM" (PRI) amounts on an average basis for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The composite average PRI for all of Class DIR is weighted by the contract months in Column (1), as documented in the footnotes.

Column (5) contains the "Current Pool Rate Alignment Basis Required Income PCPM" amounts for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The calculations are documented in the footnotes. The Class DIR composite in Column (5) is required to be the same as in Column (3), as I just discussed in my testimony. The respective

"Required Income PCPM" amounts by pool in Column (5) are calculated to maintain the same proportionate relationship as the PRI values in Column (4), i.e., no re-alignment in rates between pools.

Column (6) contains the "Required Loss Ratios" calculated for Basic (Pool I) and Preferred (Pool II), on a current pool rate alignment basis. This means that the Basic (Pool I) and Preferred (Pool II) values would retain the same relationship in required rates as is reflected in the present rates.

Q. Please turn back to Schedule 20 once again. You have now described the development of the "Required Loss Ratios, Full Experience Basis" in Column (3) and the "Required Loss Ratios, Current Pool Rate Alignment Basis" in Column (4). Is that correct?

A. Yes.

Q. The third of the three required loss ratio bases, shown in Column (5) of Schedule 20, is labeled the "Required Loss Ratio, Experience Adjusted Basis." You explain this third set of required loss ratios in your testimony as being based on a blending of the preceding two sets of required loss ratios. You state that the "Required Loss Ratio, Experience Adjusted Basis" in Column (5) was then used by Blue Cross in calculating the "Composite Required Monthly Base Rates" in Column (6). Is all this correct?

A. Yes.

Q. Please turn now to Schedule 6 and describe that schedule.

A. Schedule 6 is entitled "Calculation of HealthMate Direct 400 Required Monthly Subscription Rates for April 1, 2007 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the monthly subscription rates for Individual and Family subscribers in Basic (Pool I), separately for subscribers under age 65

versus age 65 and over. Monthly subscription rates in Schedule 6 are shown separately on a "Required Rate" basis. Calculations are documented in the footnotes.

Q. How does Schedule 6 compare with Schedules 7 through 9?

A. Schedules 7 through 9 are comparable in nature. They also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas Schedule 6 applies to HealthMate Direct 400.

Q. On a column-by-column basis, would you explain what is contained in Schedules 6 through 9?

A. Column (1) contains the "Monthly Base Rate" for each of the corresponding products for Basic (Pool I). As indicated in the footnotes, the "Monthly Base Rates" for Basic (Pool I) are developed in Schedule 18.

Column (2) is labeled "Rate Tier Normalization Factor." This is the normalization factor that corrects any imbalance in the "Rate Factors" contained in Columns (4) and (6) of Schedules 6 through 9, determined across the entire pool. The "Rate Tier Normalization Factor" is developed in Schedule 10.

Column (3) is simply Column (1) divided by Column (2).

Column (4) contains the "Individual Rate Factors," and Column (6) contains the "Family Rate Factors." These are the factors needed to convert the "Normalized Monthly Base Rate" for the product and pool to "Monthly Subscription Rates" for Individual and Family contracts and, within each, for under age 65 and age 65 and over subscriber rating categories. The factors contained in Columns (4) and (6) are based on the current rate relationships between

individual vs. family subscribers, by under and over age 65. The rate factors used are the same factors that were approved in last year's rate filing for class DIR.

Columns (5) and (7) contain the "Monthly Subscription Rates" for the Individual and Family subscriber categories respectively. The calculations are documented in the footnotes. In addition to using the "Normalized Monthly Base Rates" and "Rate Factors" contained within the schedules, the calculation of the "Monthly Subscription Rates" also includes a rate component for Organ Transplants. The development of this rate component is contained in Schedule 57.

Q. With regard to the "Rate Tier Normalization Factor" in Column (2) of Schedules 6 through 9 you refer to its development in Schedule 10. Could you please turn to Schedule 10 and describe that schedule?

A. Schedule 10 is entitled "Calculation of Rate Tier Normalization Factor". Column (1) is the "Rate Factor" that converts monthly normalized base rates to monthly subscription rates for "Individual", "Family", "Under 65", and "Ages 65 and Over" rating categories. These are the same factors used in last year's filing.

Columns (2), (3), (4), and (5) represent the Base Period Contract Months for each of the current products.

Column (6) is just an aggregation of the 4 preceding columns.

Lines (1) through (5) simply represent the enrollment by tier category and in total.

Row (6) represent the "Rate Relativity Factors" that, as I mentioned previously, are essentially the same as from last year's filing.

The remaining lines show the computational steps, as explained in the footnotes.

Q. With regard to the "Monthly Subscription Rates" in Columns (5) and (7) of Schedules 6 through 9 you refer to the development of a rate component for Organ Transplants in Schedule 57. Could you please turn to Schedule 57 and describe that schedule?

A. Schedule 57 is entitled "Organ Transplant, Calculation of Required Monthly Subscription Rates." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of this schedule is to display the calculation of the required monthly subscription rates for Organ Transplant coverage. Calculations are documented in the footnotes.

Q. Please describe the status of Class DIR Organ Transplant coverage.

A. Blue Cross has been purchasing solid organ and bone marrow transplant reinsurance for Class DIR from BCS Insurance Company commencing with the rate filing for rates effective April 1, 1988. Given the relatively small Class DIR population, coupled with the high costs of individual claims in this area and the uncertainty of the exposure arising out of this coverage, Blue Cross determined that reinsurance was appropriate for both solid organ transplant and bone marrow transplant coverage.

The organ transplant reinsurance coverage from BCS Insurance covers 90% of the claims risk. Acquisition of the reinsurance is transparent to the subscribers. The proposed rates in this filing for organ transplant coverage reflect the reinsurance capitation per contract month, plus an amount reflecting the 10% claims risk that Class DIR has retained.

Q. Please explain what is contained in Schedule 57.

A. Columns (1) and (2) of Schedule 57 reflect the Individual and Family values for solid organ transplant coverage; Columns (3) and (4) reflect the same information for bone marrow transplant coverage. Line 1 reflects the 90% reinsurance capitation rates per contract month for the BCS Reinsurance in 2007. Line 2 reflects the corresponding projected

Blue Cross exposure at 10% for the same period, based on the BCS capitation levels. Line 4 contains the composite projection factors, which are developed in Schedule 58. Line 6 contains the investment income credit per contract month, and Line 7 contains the contribution to reserve/Federal tax liability per contract month. The calculations of these lines are documented in the footnotes. Both are computed in a manner similar to that used for the Blue Cross underwritten portion of the products in Class DIR, as described in Schedule 22.

Q. With regard to the "Composite Projection Factors" in Line 4 of this schedule, you refer to their development in Schedule 58. Could you please turn to Schedule 58 and describe that schedule?

A. Schedule 58 is entitled "Organ Transplant, Calculation of Composite Projection Factors for Incurred Claims Expense." This schedule shows the development of the "Composite Projection Factors" used in Line 4 of Schedule 57. The projected increases were obtained directly from BCS Insurance Company. Schedule 58 weights these projected increases with the appropriate number of months within the rate period from calendar years 2007 and 2008.

Q. Please turn back now to Schedule 6. You described the calculations involved in Columns (5) and (7) of Schedule 6. The result is what is shown in these two columns as the Basic (Pool I) "Monthly Subscription Rates" for HealthMate Direct 400. Is that correct?

A. Yes. The resulting "Monthly Subscription Rates" are contained in Columns (5) and (7) for Individual and Family subscribers, respectively.

Q. Schedule 6 applies to the HealthMate Direct 400 product under Basic (Pool I). You testify that Schedules 7 through 9 are comparable, for the other three product rates for Basic (Pool I). Is that also correct?

A. Yes.

Q. You state that Schedules 6 through 9 apply to Basic (Pool I), for each of the four products being offered. Are there comparable schedules for Preferred (Pool II)?

A. Yes. Schedules 12 through 15 correspond to Schedules 6 through 9, for Preferred (Pool II) versus Basic (Pool I). Schedule 16 also corresponds to Schedule 10.

Q. Please turn to Schedule 12. Are the same calculations carried out for the HealthMate Direct 400 product in Schedule 12 for Preferred (Pool II) as in Schedule 6 for Basic (Pool I)?

A. The same types of calculations are carried out in Schedule 12 for Preferred (Pool II) as in Schedule 6 for Basic (Pool I).

I would note that the format and structure of Schedule 12 differs slightly from Schedule 6; labeling and rate development is consistent, however. The structural difference occurs since Preferred (Pool II) has separate Individual rates for Male vs. Female subscribers, and has rates for subscribers under age 65 that vary by age band.

Q. You state that Schedules 12 through 15 for each of the Preferred (Pool II) products correspond to Schedules 6 through 9 for Basic (Pool I). You have just described Schedule 12. Are there any differences between Schedules 13 through 15 and Schedule 12, other than applying to the other products under Preferred (Pool II)?

A. No. The same calculations are carried out, and the same issues are present.

V. CONCLUSION

Q. Are the rates developed in Exhibit 3 and displayed in Schedules 6 through 9 and 12 through 15 consistent with rates presented in your letter dated November 20, 2006 and included as Blue Cross Exhibit 2?

A. Yes, the rates in these two documents are the same.

Q. Were Blue Cross Exhibit 3, Schedules 1 through 65 prepared by you or under your direction and supervision?

A. Yes. These schedules were prepared by my staff in the Actuarial and Statistical Analysis Department of Blue Cross.

Q. Were Blue Cross Exhibit 3, Schedules 1 through 65 prepared using generally accepted actuarial principles and were those principles consistently applied?

A. Yes.

Q. Is it your opinion, to a reasonable degree of actuarial certainty, that Blue Cross Exhibit 3, Schedules 1 through 65, reflect fair, accurate and reasonable computations of required rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

A. Yes.